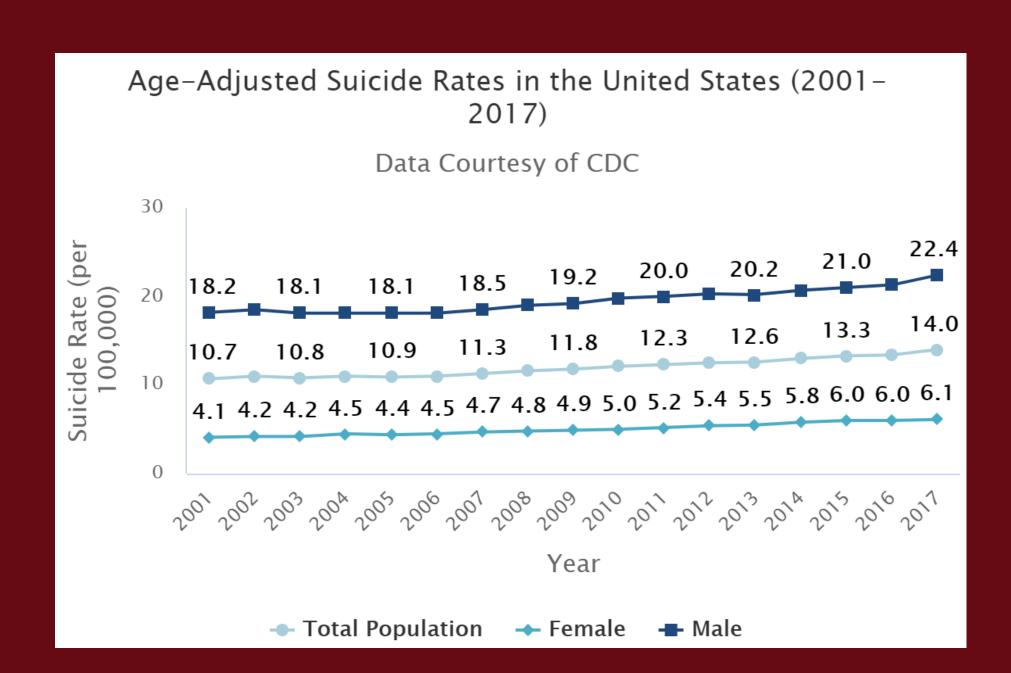
Suicidality in adolescents

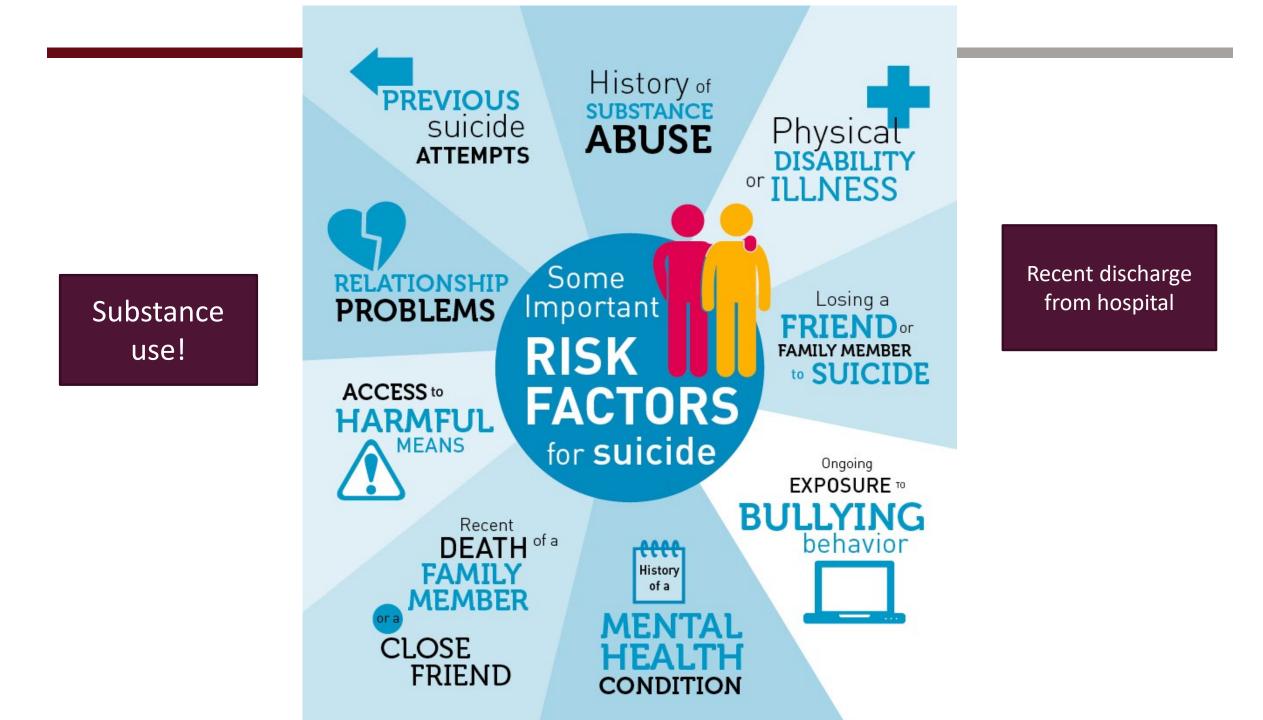
ADOLESCENT SUBSTANCE USE ECHO

MAY 22, 2019

ALLYSON L. DIR, PHD







Warning signs of suicide

- Obsession with death or frequent conversations about death
- Direct or indirect threats of suicide
- Hints about life not worth living "hopeless", "helpless", "I shouldn't be here", "it'd be better off if I wasn't around"
- Intense and overwhelming guilt, shame, rejection
- Sudden mood improvement after period of depression that is out of the ordinary for individual

Increased irritability

- Changes in eating or sleeping
- Changes in personality or demeanor
- Changes in school performance or involvement in other extracurricular activities
- Putting affairs in order (getting rid of important possessions)



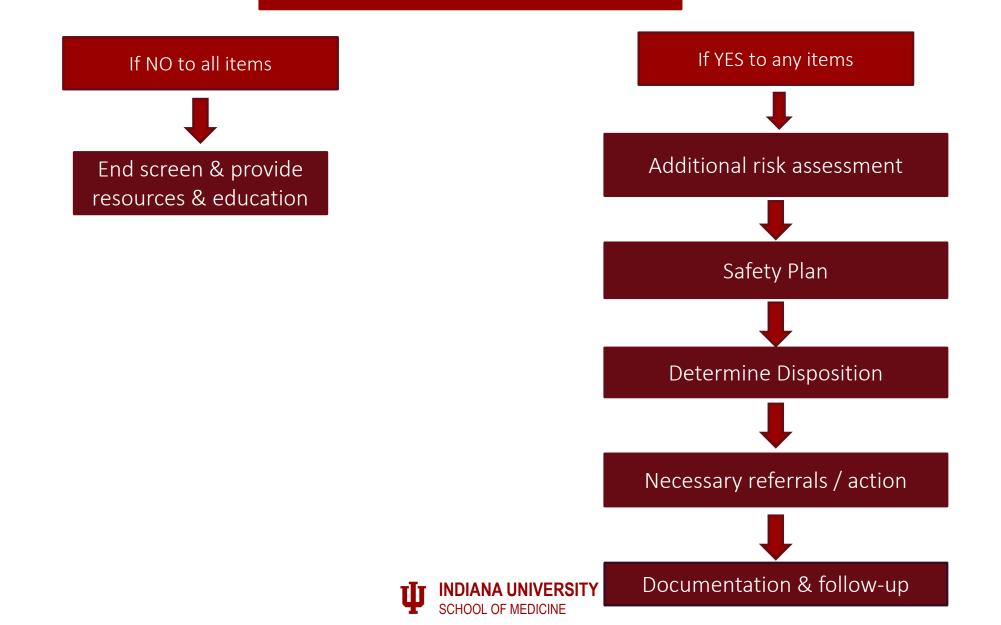
When should I screen for suicide risk?

- Myth: asking about suicide gives an individual thoughts / ideas
- Suicide screening should be routine!
 - Preventative
 - Models to parents about discussing with youth
 - Demonstrates to youth that it's OK to talk about it





Initial suicide risk screen



Initial suicide risk screen

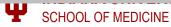
| asQ | | |
|---|-----|--|
| Ask Suicide-Screening Questions | | |
| Ask the patient: | | |
| In the past few weeks, have you wished you were dead? | Yes | No |
| In the past few weeks, have you felt that you or your family would be | | |
| better off if you were dead? | Yes | No |
| 3. In the past week, have you been having thoughts about killing yourself? | Yes | No |
| 4. Have you ever tried to kill yourself? | | No |
| If yes, how?When? | | |
| If the patient answers yes to any of the above, ask the following question: | | |
| 5. Are you having thoughts of killing yourself right now? | Yes | No |
| If yes, please describe: | | National Institute of Mental Health |

SCHOOL OF MEDICINE

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Additional suicide risk assessment

| 1. Praise Patient | \cdot Validate them for sharing |
|--|---|
| 2. Assess with patient alone | Ideation: frequency, intensity, duration, note if current ideation (i.e., within past 48 hours) Suicide plan, intent, previous behaviors/attempts Warning signs: changes in sleep/appetite, mood, isolation, etc. Risk factors: recent break-up or loss, family conflict, significant life change, family history, recent hospital discharge |
| 3. Assess with parent & patient | Share with parent Re-assess warning signs, risk factors with parent report |
| 4. Safety Plan (NOT safety contract) | Identify people they will tell if having thoughts Identify coping strategies Determine means restriction (removal of firearms access, medications, other lethal items) Ask patient: Do you think you need help to keep yourself safe? |



| Intervention | Risk & Protective Factors | Suicidality |
|--|--|--|
| ED referral | Acute psychiatric symptoms, acute precipitating event NO current mental health provider Patient/parent doesn't feel they can stay safe | Current and/or intense ideation with plan and intent Past suicide behavior or attempt |
| Immediate mental health referral or connection to provider | Non-acute psychiatric symptoms Safety plan with coping strategies & contacts identified | Suicidal ideation with plan but no intent or behavior |
| Non-urgent mental health referral / follow- up | Safety plan in place Risk factors modifiable Few warning signs | Thoughts of death, no plan, intent, or behavior |



Provider Resources

- NIMH asQ Suicide toolkit
 - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml
- Suicide Resource Prevention Center
 - https://www.sprc.org/
- SAMHSA suicide resources
 - https://www.samhsa.gov/find-help/suicide-prevention



Patient / Parent Resources

- National Suicide Prevention Lifeline
 - 1-800-273-TALK (8255)
- 24/7 Crisis Text Line
 - Text "HOME" to 741-741
- Covenant House Nine Line
 - 1-800-999-9999

